BOSTON ORTHOPAEDIC & SPINE

REVOCATION OF AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION

Purpose

This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice to Boston Orthopaedic & Spine, LLC.

Patient Information

Patient's Name: _____Telephone #: _____

Patient's Address: _____ D. O. B.: _____

City: _____ State: _____ Zip: _____

I (the above patient or authorized representative of the above patient) hereby revoke (cancel) my previous authorization and take back my permission for Boston Orthopaedic & Spine, LLC to share records with:

Name: _____ Telephone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____ Email: _____

I Understand and Agree that:

- This form only applies to future information. Records that were shared with my previously written permission cannot be taken back.
- That this revocation will not be in effect until Boston Orthopaedic & Spine, LLC receives it.
- A copy of this Written Notice of Revocation shall be placed in my medical record.

X_____ _____ _____ _____

Patient or Authorized Representative's Signature *Print Name* *Relationship to Patient* *Date*

This revocation of authorization form must be completed in its entirety or it will not be processed.